

treatment. Untreated it may last several months, occasionally several years. Among my cases, Case I., which was pretty steadily under treatment, recovered in eight months. Case II., which continued constantly under my supervision and careful treatment, recovered in ten months. Case III. however, where treatment was employed only at irregular intervals and for short periods, was characterized by several relapses, and when last seen, some ten months after the affection first appeared, was not cured, nor even markedly ameliorated.

ARTICLE VIII.

REMOVAL OF A LARGE, INTERSTITIAL UTERINE FIBROID. By T. GAILLARD THOMAS, M.D., Professor of Diseases of Women in the College of Physicians and Surgeons, New York.

No variety of uterine myoma is possessed of more interest and importance, from a surgical standpoint, than that which develops within the interstitial structure of the uterus, projects very decidedly neither towards the peritoneum nor the endometrium, and receives the name of interstitial or intra-mural tumour. The surgical resources at our disposal for sub-mucous growths which occupy the cavity of the uterus, as well as for those even of the largest size, which are attached to the peritoneal surface of the uterus, and occupy the abdominal cavity, are at the present day very efficient and satisfactory. This is by no means the case with the interstitial fibroid, and every advance in the direction of its systematic treatment by surgical means will be received with favour where there is so much need of improvement in our resources.

The following case is related, not as an isolated and desultory example of a remarkable operation, but as an illustration of a system which, by its efficiency and simplicity when applied to appropriate cases, will in the future, I trust, accomplish a great deal of good where at present very little effort at surgical relief is ever made.

Georgiana P., æt. thirty-six years, who has been married fourteen years, and had one child twelve years ago, since which time conception has not occurred, was admitted to my service in the Woman's Hospital, Dec. 20, 1879. The patient was perfectly well until April, 1879, when, just after a menstrual period, she was suddenly seized with profuse uterine hemorrhage, accompanied by severe uterine tenesmus. This lasted only twenty-four hours, but it exhausted her very much indeed. At every menstrual epoch which has occurred since that time she has had profuse hemorrhage, with what she styles "bearing-down pains." This has lasted usually about nine days. During the months of July and August she suffered very much from dysuria and rectal tenesmus. For the last four or five months before admission she had been almost entirely unable to walk,

because locomotion created the "bearing-down pains" already alluded to. She declared that up to April, 1879, she was in excellent health. She was anæmic, very pale, and extremely weak. During the month of October, hemorrhage was so severe that a vaginal tampon had to be applied repeatedly to check the excessive discharge of blood.

Upon physical examination the uterus was found very large, the fundus extending up to a point midway between the umbilicus and ensiform cartilage. The cervical canal was distended so as to admit the tip of the index finger freely. The posterior uterine wall, including the cervix, was immensely hypertrophied, and out of all proportion to the anterior. The uterine cavity, measured by an elastic sound, was found to have a depth of nine and a half inches, the sound passing upwards, and then inclining somewhat backwards towards the spinal column. The following diagram will convey a more correct idea to the mind of the reader than a much more lengthy description in words would accomplish.

The patient, with her husband, had come from Colorado Springs, and was exceedingly desirous to have some curative treatment adopted, for

Fig. 1.

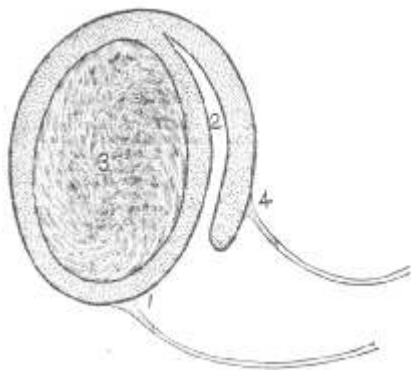


Diagram representing the tumour imbedded in the posterior wall of the uterus. 1 shows the projecting posterior wall; 2, the uterine cavity; 3, the tumour; 4, anterior uterine wall at the point of attachment of the anterior vaginal wall.

experience had taught her the inutility of the treatment by ergot, preparations of lime, and the various other therapeutical resources which are ordinarily adopted in cases such as hers. Accordingly, she was seen with me in consultation by a number of my colleagues of the hospital staff, before whose consideration I laid the operation which this paper will describe; and I was thoroughly sustained in the resort to it.

The propriety of the operation and the urgent demand for prompt action in this case were from the first quite clear to my mind, and at no time did

any doubts as to the justice of this conclusion present themselves. The reasons for my convictions were the following:—

1st. My experience with the spoon-saw in a large number of cases made me feel confident that success would crown my efforts as to the mere surgical part of the work.

2d. The tumour, already large, was growing fast, and, in a few months, the abdomen would have had to be opened to give exit to it.

3d. The patient was losing large amounts of blood, and growing, of course, steadily weaker, and progressively more despondent.

4th. She lived in Colorado, far away from any surgical centre, and, if

she were sent away now, it was highly improbable that, weakened by hemorrhage, discouraged by failure to obtain relief from surgery, and alarmed by the great and increasing size of the abdomen, she would ever again make an attempt to save her life. In the present I saw a courageous and comparatively strong and healthy woman, with a fairly good blood state, unimpaired nerve condition, efficient digestive function, and a tumour weighing two pounds, not willing merely, but eager for operation. In the future I foresaw an anæmic, feeble, and despondent one with impaired digestion, an exhausted nervous system, and a tumour weighing eight or ten pounds, still willing to submit to operation perhaps, but doing so with diminished hope and lessened enthusiasm.

On the 5th of January I proceeded to remove the tumour in the following manner, and in the presence of Prof. Alfred C. Post, and Drs. Emmet, C. C. Lee, J. B. Hunter, C. S. Ward, H. D. Nicoll, S. B. Jones, and the house staff of the hospital. The patient, having been etherized, was placed in Sims's position upon a strong table before a window admitting a good light. During the steps of the operation I was ably assisted by the assistant surgeons in my department, Drs. Ward and Nicoll. Sims's largest speculum having been introduced, and the perineum and posterior wall of the vagina lifted by it, I caught the uterine wall at the point marked by the figure 1 (Fig. 1), and, by means of a pair of long-handled scissors, snipped a piece out of it, extending deeply into its structure. Upon this a very free flow of blood occurred, but I disregarded it, and as I proceeded with the operation it very soon ceased. Keeping a strong tenaculum fixed in the uterine tissue between the figure 1 and the posterior vaginal walls, I now passed my right index finger into the opening which I had made, and in this way enlarged it somewhat. Then taking a very strong and large grooved director, I forced it upwards towards the figure 2, and sliding a knife in its groove, I slit the enveloping uterine wall high up into the uterine cavity. By the finger I now enlarged the opening thus made, and was at once gratified by the sight of the white fibrous structure of the tumour of which I was in search. Into this I at once fixed a powerful pair of vulsellum forceps, and taking the spoon-saw shown in Fig. 2, I swept it around, and detached the tumour from its uterine bed for about an inch and a half or two inches all around.

I now made traction upon it with the vulsellum, but found that the tumour was too large to be dragged down into the pelvis. Taking, then, a pair of long-handled scissors, I cut out the portion of the tumour within the bite of the forceps, removing a piece about as large as a hen's egg. Then seizing another portion of the tumour, I cut it out, and continuing in this way I removed, piecemeal, all that portion which I had detached by the spoon-saw.

I now seized the tumour again with the vulsellum forceps, and detach-

Fig. 2.



The spoon-saw.

ing, by means of the spoon-saw, about an inch and a half more of it, I removed it piecemeal by the scissors as already described. This process I repeated till about one-third of the tumour only remained, when I detached the entire mass with the spoon-saw, and drew it away.

The operation lasted one hour and twenty minutes. After the first incision it was accompanied by almost no hemorrhage, and the patient bore it remarkably well. At its conclusion the large cavity left by the removal of the tumour was syringed out with strongly carbolized water, and stuffed to its full capacity with carbolized cotton. The patient was put to bed; given a full dose of morphia hypodermically; kept very warm by the application of artificial heat; as soon as she could swallow, given brandy and water in small amounts at short intervals, and kept upon the general regimen usually adopted as preventive of shock.

I shall not weary the reader with a detailed account of the progress of the case; suffice it to say, that no bad symptoms developed themselves, and that to-morrow, February 5, just one month after the performance of the operation, the patient expects to leave the hospital for her home.

The tumour weighed exactly two pounds, and was a good example of the ordinary myo-fibroma. It must be remembered that its duration is unknown. True, it was discovered in April, 1879, but it is highly probable that it had existed long before that time.

At the conclusion of the operation, an eminent surgeon who was present remarked that he was surprised that I had depended so little upon the spoon-saw in its performance. My own feeling in regard to the matter is this: Without the spoon-saw nothing would have induced me to touch this case; with it at my disposal, I would willingly undertake to cope with any number of similar ones. After having detached segment after segment of the lower portion of the tumour, dismemberment and removal of parts of it were easy. An attempt to excise and remove the growth before detachment would, I think, have very soon been followed by the filling of the vaginal canal with intestines.

During the past ten years I have removed a great many large submucous tumours, but only once before, October, 1878, have I removed one of truly interstitial character. That weighed eight ounces, and was removed exactly as this one was, except that the dismemberment of that by the scissors was not necessary.

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ARTICLE IX.

ON THE DIAGNOSIS OF FRACTURES AND DISLOCATIONS, WITH A VIEW TO THE ESTABLISHMENT OF PATHOGNOMONIC PRINCIPLES. By L. A. DUGAS, M.D., LL.D., Prof. of Surgery in the Medical College of Georgia.

THE difficulties presented in making a correct diagnosis in injuries of the limbs, and especially of fractures and dislocations, are too generally conceded to require any illustration at our hands. We will therefore pro-